

**DEPARTMENT OF HEALTH AND FAMILY SERVICES**Division of Public Health  
DPH 4818 (Rev. 11/00)**STATE OF WISCONSIN**

s. 255.075, Wis Stats.

**WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT**

Read instructions on reverse prior to completing this form. Print clearly. Client information in this document is confidential under Wis. Stats 146.82

**PERSONAL INFORMATION – Completed by Client**

1. Last Name \_\_\_\_\_ 2. First Name \_\_\_\_\_ 3. Middle Name \_\_\_\_\_

4. Maiden Name \_\_\_\_\_ 5. Date of Birth (mm/dd/yyyy) \_\_\_\_\_ 6a. Social Security No. (Optional) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

6b. Client Identification No. (Assigned by Local Coordinating Agency) \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

7. Race ☐ Aleutian ☐ American Indian ☐ Asian ☐ Black ☐ Eskimo ☐ Hmong ☐ Other ☐ Pacific Islander ☐ Unknown ☐ White

8. Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

9. Street Address \_\_\_\_\_ 10. City \_\_\_\_\_ 11. State \_\_\_\_\_ 12. Zip \_\_\_\_\_

13. County \_\_\_\_\_ 14. Day Telephone No. (\_\_\_\_\_) \_\_\_\_\_ 15. Night Telephone No. (\_\_\_\_\_) \_\_\_\_\_

16. Mailing Address \_\_\_\_\_ 17. City \_\_\_\_\_ 18. State \_\_\_\_\_ 19. Zip \_\_\_\_\_

20. Name of contact person, not living with you \_\_\_\_\_ 21. Relationship \_\_\_\_\_

22. Address \_\_\_\_\_ 23. City \_\_\_\_\_ 24. State \_\_\_\_\_ 25. Zip \_\_\_\_\_

26. Contact Person's Day Telephone No. (\_\_\_\_\_) \_\_\_\_\_ Night Telephone No. (\_\_\_\_\_) \_\_\_\_\_

**ENROLLMENT INFORMATION – Completed by Enrollment Site**

27. Enrollment Site Name \_\_\_\_\_ 28. Site City \_\_\_\_\_

29. Site County / Tribe \_\_\_\_\_ 30. Enrollment Date (mm/dd/yyyy) \_\_\_\_\_

31. Enrollment Site Number (if known) \_\_\_\_\_

**INSURANCE INFORMATION – Completed by Client**

32. Do you have any health insurance? ☐ Yes ☐ No 33. Do you have Medicare Part B? ☐ Yes ☐ No

**HEALTH CARE PROVIDER INFORMATION – Completed by Client**

34. Do you have a primary health care provider? ☐ Yes ☐ No 35. If Yes, Name of Provider \_\_\_\_\_

36. Street Address \_\_\_\_\_ 37. City \_\_\_\_\_ 38. State \_\_\_\_\_ 39. Zip \_\_\_\_\_

40. Do you have a primary care clinic? ☐ Yes ☐ No 41. If Yes, Name of Clinic \_\_\_\_\_

42. Street Address \_\_\_\_\_ 43. City \_\_\_\_\_ 44. State \_\_\_\_\_ 45. Zip \_\_\_\_\_

46. How did you hear about this program? ☐ WWWP Coordinator ☐ Relative / Friend ☐ Radio / TV ☐ Newspaper ☐ Brochure / Poster  
☐ Clinic / Health Care Provider ☐ Other \_\_\_\_\_

**47. CLIENT PARTICIPATION AGREEMENT**

I understand and agree to the following; the Wisconsin Well Woman Program (WWWP) will use the personally identifiable information only for program enrollment and case management. I give WWWP permission to release my medical information to the Local Coordinating Agency (LCA), other service providers, referral agencies and the State of Wisconsin. I understand that WWWP pays for preventive screening services, but does not pay for medical treatment services. I have seen the current program eligibility criteria and, to the best of my knowledge, my annual income does not exceed them. All of the information I have given is true and correct. I will inform the WWWP LCA if I move or if I no longer wish to participate. I understand the enrollment is valid for one (1) year from the date signed.

**48. SIGNATURE – Applicant****49. Date Signed****50. SIGNATURE – Witness****51. Date Signed****Office Use Only**

<input type="checkbox"/> New Enrollment	<input type="checkbox"/> Meets Eligibility Requirements	<input type="checkbox"/> Age _____	<input type="checkbox"/> Income \$ _____	<input type="checkbox"/> Household size _____	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Underinsured
<input type="checkbox"/> Re-Enrollment	<input type="checkbox"/> Meets Eligibility Requirements	<input type="checkbox"/> Age _____	<input type="checkbox"/> Income \$ _____	<input type="checkbox"/> Household size _____	<input type="checkbox"/> Uninsured	<input type="checkbox"/> Underinsured
<input type="checkbox"/> Inactive	<input type="checkbox"/> Out or Area	<input type="checkbox"/> Deceased	Date _____ (mm/dd/yyyy)			
<input type="checkbox"/> Refer for CBE and / or Mammogram		Provider Name _____				
<input type="checkbox"/> Refer for Pelvic and PAP		Provider Name _____				
<input type="checkbox"/> Refer for other Well Woman Screening		Provider Name _____				

**Name of Interviewer** \_\_\_\_\_**Return completed, white copy only, of form to: WWWP – Fiscal Agent, P. O. Box 6645, Madison, WI 53716-0645**

White (Top) Copy – Fiscal Agent

Yellow (2<sup>nd</sup>) Copy – ProviderPink (3<sup>rd</sup>) Copy – Local Coordinating AgencyBlue (4<sup>th</sup>) Copy – Client

## **WISCONSIN WELL WOMAN PROGRAM (WWWP) ENROLLMENT INSTRUCTIONS**

Completion of this form is required to determine your eligibility for services with WWWP. The Department of Health and Family Services has the authority to collect personally identifiable information necessary to determine eligibility for services for the WWWP. The personally identifiable information collected on this form will ONLY be used to determine eligibility for services and case management. Provision of the Social Security Number is optional.

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### PERSONAL INFORMATION

1. Print your last name.
2. Print your first name.
3. Print your full middle name.
4. Print your maiden name, if applicable.
5. Indicate date of birth. Use numbers for month, day and year, i.e. 01/15/1935.
6. Indicate your Social Security Number.  
6a. Your Social Security Number is optional and will be used to determine your eligibility for services and to identify your status with other health care programs.  
6b. If Client Identification Number is used instead of the Social Security Number, the Local Coordinating Agency should assign this number.
7. Indicate your race by checking the appropriate box. This information will be used for statistical purposes only.
8. Indicate your ethnicity by checking the appropriate box. This information will be used for statistical purposes only.
9. Indicate number and street address of your residence; include apartment number if applicable.
10. Indicate your city of residence.
11. Indicate your state of residence.
12. Indicate your residential zip code.
13. Indicate your county of residence.
14. Indicate your daytime telephone number, with area code.  
If there is no phone, indicate "none".
15. Indicate your night / evening telephone number, with area code. If there is no phone, indicate "none".
16. Indicate your mailing address, if different from your residential street address.
17. Indicate the city of your mailing address, if different from your residential address.
18. Indicate the state of your mailing address, if different from your residential address.
19. Indicate the zip code of your mailing address, if different from your residential address.
20. Indicate the name of a contact person, not living with you. This person should have a telephone.
21. Indicate the relationship of the contact person to you, i.e. husband, mother, son, neighbor, etc.
22. Indicate the contact person's address.
23. Indicate the city for the contact person's address.
24. Indicate the state for the contact person's address.
25. Indicate the zip code for the contact person's address.
26. Indicate the contact person's day or evening telephone number, with area code. If there is no phone, indicate "none".

29. Indicate the county or tribe of the enrollment site.
30. Indicate the enrollment date. Use numbers for month, day and year, i.e. 01/15/2001.
31. Indicate the enrollment site number (if known).

### INSURANCE INFORMATION

32. Check "Yes" if you currently have private, group or other Health Insurance coverage as well as any other type of coverage. Check "No" if you do not.
33. Check "Yes" if you receive Medicare Part B. Check "No" if you do not.

### HEALTH CARE PROVIDER INFORMATION

34. Check "Yes" if you have a primary health care provider (physician). Check "No" if you do not.
35. Indicate the name of your primary health care provider.
36. Indicate the street address for your primary health care provider.
37. Indicate the city where your primary health care provider is located.
38. Indicate the state where your primary health care provider is located.
39. Indicate the zip code for your primary health care provider.
40. Check "Yes" if you have a primary care clinic. Check "No" if you do not.
41. Indicate the name of your primary care clinic.
42. Indicate the street address of your primary care clinic.
43. Indicate the city where your primary care clinic is located.
44. Indicate the state where your primary care clinic is located.
45. Indicate the zip code where your primary care code is located.
46. Please indicate how you heard about the Wisconsin Well Woman Program by checking the appropriate box.

### CLIENT PARTICIPATION AGREEMENT

47. Read the agreement carefully. If you have any questions regarding completion of this form, contact your Local Coordinating Agency.
48. Sign the agreement using your legal signature.
49. Indicate the date on which you sign this form.
50. The witness signature will verify that the client signed this form.
51. The witness will indicate the date that he / she signed this form.

### ENROLLMENT INFORMATION

27. Indicate the client's enrollment site name. (example: Wisconsin County Medical Center)
28. Indicate the city of the enrollment site.

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**Return completed form, White (Top) Copy Only to:**

**WWWP  
P. O. BOX 6645  
MADISON, WI 53716-0645**